Montana State
Trauma Care
Committee

# *Department of Public Health & Human Services, Helena*

## Meeting Minutes
## August 10, 2011

## I. Call to order

**Dennis Maier, MD, FACS** called to order the regular meeting of the **State Trauma Care Committee** at **1130** on **August 10, 2011** in **Helena, MT**.

## II. Roll call

Roll call was conducted and the following persons were present:

**Present:** Lauri Jackson, Andrew Michel, Freddie Bartoletti, Elaine Schuchard, Brad Pickhardt and Sam Miller.
Lyndy Gurchiek, Justin Grohs and Brad Vonbergen attended by teleconference.

**Absent:** Pauline Linnell, Krissy Lowery, Lyndy Gurchiek and Jonathan Weisul

**Guests:** Bobbi Perkins, Gail Hatch, Jennie Nemec, Carol Kussman, John Bleicher, Traci Jasnicki, and Lindsey McCurdy.
Marla Leedy, Brad Vonbergen, Chuck Bratsky and Drew Goss attended by teleconference.

**Handouts**

- Agenda & previous meeting minutes
- CRTAC, ERTAC & WRTAC meeting minutes
- Articles/Guidelines;

- Impact of Improved Combat Casualty Care on Combat Wounded Undergoing Exploratory Laparotomy and Massive Transfusion; JOT, Vol 71, #1, July Supplement 2011
- Joint Theater Trauma System Clinical Practice Guidelines for Hypothermia Prevention, Monitoring and Management

## III. RTAC Reports

### a) Central RTAC report given by Lauri Jackson

The last CRTAC meeting was July 6, 2011 and hosted by Benefis Healthcare with good attendance. CRTAC meeting minutes were available for review.
State report was given by Jennie Nemec & Carol Kussman. EMS subcommittee met and has decided to work on two PI focus projects: 1) Documentation of GCS per EMS & airway management if < 8 and 2) Backboard padding for immobilized patients
Lauri reported on a Distracted Driving Course conducted utilizing cellphone/texting as the "distraction" while driving a vehicular "obstacle" course.
Of note, results for those participating in the course with and without texting showed with texting while driving, an overall 10% decrease in speed of driving, but a 150% increase in problems/mistakes made during the course over those made not texting while driving.
Plans are to set up the course on the first day of High Scholl at CM Russell HS in Great Falls.

Case review: Shelby, Conrad and Choteau facilities & EMS participated in presenting the bus crash case review involving 40 patients. Luckily, there were few serious injuries. All responders and facilities involved in the crash are to be commended for their excellent efforts and timely responses. Issues identified included communications, scene organization and coordination of patient transport/care with corresponding facilities.

The next CRTAC meeting is scheduled for October 20, 2011 at Benefis Health Care

### b) Eastern RTAC report given by Brad Vonbergen

The last ERTAC meeting was June 9, 2010 at the Saint Vincent Healthcare. ERTAC meeting minutes were available for review.
Case reviews included management of open fractures, multiple patients to and from sending/receiving facilities, infusion of blood earlier when indicated for those facilities with transfusion capabilities, management/care of blunt pelvic injury including splinting/binders and discussion of transport decisions/capabilities re; BLS/ALS interface when resources are depleted locally.

The Rimrock Trauma Conference is to be scheduled for the day before Billings ATLS, November 3, 2011.
Elaine Schuchard presented the Education subcommittee report.
Jennie Nemec & Carol Kussman provided the state Trauma System update.

The next ERTAC meeting is scheduled for September 8, 2011 and hosted by Billings Clinic.

### c) Western RTAC report given by John Bleicher

The WRTAC meeting was held July 8 hosted by St Patrick Hospital in Missoula. WRTAC meeting minutes were available for review.
Nursing Education group was a round-robin for members to present "lessons learned" from ACS & state verification/designation survey visits.
EMS Medical Directors/EMS group met to determine to re-establish their purpose, leadership & structure/agendas for future meetings to ensure best use of meeting times. It was decided to also present and educational topic/session for each meeting to further engage those attending.
Case reviews included 10 cases presented by 4 facilities. Issues addressed included two patients whose injuries presented more difficult to manage due to concurrent Coumadin usage, discussion of appropriate diagnostic/admission/observation parameters given Coumadin usage for various

scenarios and initial injury severity (or lack of it), contracoup head injury management, discussion of more aggressive care for elderly trauma patients given varying presentations and comorbidities and interfacility transfer challenges.

Jennie Nemec & Carol Kussman gave the Trauma System Update.
The MT Advanced Airway study preliminary results will be presented @ RMRTS in September, 2011.
The next WRTAC meeting is scheduled for October 7, 2011 hosted by Community Medical Center in Missoula.

## V. State Trauma Care Committee Strategic Planning

Members reviewed the Montana Statute and Administrative Rules regarding STCC, its purposes and defined activities. Members agreed that STCC meeting content have consistently grown as to the amount of meeting time state programs spend reporting activities and providing updates to the committee. Sending out program updates in advance of the meetings for members to review would be productive. Meeting and member time could then be better utilized for addressing the issues identified by programs, strategizing approaches to Trauma System PI projects and processes and conducting peer review for pertinent cases. Meeting time will not regularly be spent on reviewing program updates.

Specific STCC meeting components were discussed at length, including;

1) Trauma Registry Data; TR data has been more consistently and regularly reported for the last 7 years. Members agreed they'd like the office to continue to run current data and track current data trends, but would prefer reviewing data that illuminated new/differing issues, emerging trends, changing/problem areas and Performance Improvement issues as they become apparent within the data. STCC can then focus on documented problems and concerns. Suggestions; Patient temperature/hypothermia and inter-facility transfer issues.

2) Designation information; members suggested they'd appreciate further information/updates on the issues obtained during trauma site reviews, including Regional/State PI trends, weaknesses in care, program strengths, creative solutions and good practices.

3) Members should be prepared to report to STCC "What's New" in their worlds to further inform and share information valuable to the committee.

4) Case Reviews; the cases brought to STCC , usually by Regional TCs to illustrate regional/system issues & peer review, should share some common themes including,

   - Identification of issues not yet resolved with STCC to focus on strategies for those issues in context of their importance/priority.

   - The "point" of Regional cases brought to STCC for review should be primarily two-fold; areas for potential improvement and/or "lessons learned" in order to provide best use of state review.

   - Cases that "stress" the System and its components/phases of care should also be brought for review(such as multiple/mass casualty scenarios, depletion of resources, lack of available resources)

   - Cases that are interesting BUT highlight regional/state processes and provide opportunities for targeted education STCC can advise and/or direct.

- Information dispersal; once strategies have been determined, case issues should provide an avenue for improved informational dissemination; education, best practices, evidence-based changes or trends.

## VI. Subcommittee Reports

Education Subcommittee:
TNCC course have been scheduled. MT Trauma System Conference is scheduled for Wednesday, September 21 in Kalispell at the Red Lion Inn followed by Rocky Mountain Rural Trauma Symposium September 22 & 23, also at the Red Lion Inn.
The Rimrock Trauma Conference will be a joint project between St Vincent's & Billings Clinic and will be conducted in Billings November 3, 2011.

PI/EP Subcommittee:
PI summary information, Designation & EP activities were reviewed previously. Additional PI parameters will likely be identified during the Preventable Mortality study and those should be included as prioritized PI activities.

## VII. New Business; State PI Topics; Jennie Nemec

**A.Review of JOT article** (see handout) illustrating strategies utilized to improve (by 50%) mortality between two study groups in US military in Iraq/Afghanistan including;

- Trauma Systems approach, including tiered evacuation of trauma patients "up the chain" of increasing capabilities

- PI projects including hypothermia prevention and management

- Transfusion/Resuscitation strategy; changes in blood component transfusions(more blood components administered RBCs: FFP: Platelets, 1:1:1 and sooner when indicated) and decrease in crystalloid infusion by 61%

- Pre-hospital strategies implemented; use of tourniquets for extremity trauma, and *implementation of the JTTS Clinical Practice Guidelines for Hypothermia Prevention, Monitoring and Management for ALL phases of care and ALL Providers throughout the Joint Theater (see handout).*

  The clinical guidelines address the background and philosophy all in Joint Trauma Theater have adopted for the military. Included is direction for the use of specific cost-effective equipment/supplies progressively up all phases of care and evacuation/transport planning including; Hypothermia Prevention & Management kits with Blizzard Rescue blankets, hypothermia caps and" ReadyHeat" torso blankets (a self-heating blanket activated by exposure to air, placed on front/back of patient torso prior to being wrapped in Rescue Blanket) instantly heats up to max temperature of 104F and for up to 8 hours and placemen of a "temp-Dot " on patient's foreheads to both facilitate temperature documentation and remind everyone of importance of the hypothermia prevention startegies. Heated IV fluids/transfusion components, and measurement/documentation of patient temperature is an additional measurement of compliance expected for all providers in all phases of care as well.

Discussion followed regarding the similarities in the military setting and that of rural Montana; limited resources, few responding providers (both pre & in-hospital), long geographic distances, enhanced facility/system transfer linkages "up the chain" of care capabilities and the need to PREVENT hypothermia in bleeding patients so as to more successfully resuscitate them with easily implemented, cost-effective strategies.

Many MT Facilities have implemented warming strategies and many EMS Services utilize hypothermia interventions but few system-wide strategies linking all phases of care have been emphasized. Further, "Hypothermia" management has often been utilized most consistently for "the hypothermic" and most consistently in times of wet/cold weather. We have not traditionally, as a trauma system, widely adopted a specific approach to *prevention* of hypothermia in bleeding patients.

Hypothermia in trauma patients occurs irrespective of ambient temperatures, up to 66 % of trauma patients arriving at facilities (where many continue to become even colder), is extremely resource-intensive and difficult to reverse, and ultimately markedly adversely affects patients outcomes. Optimally, a comprehensive approach should also address hypothermia prevention/management clinical strategies in the context of both patient resuscitation and *prevention of further heat loss for all patients.*

The guidelines represent a comprehensive philosophical approach to potentially adopt with cost-effective strategies to explore for Montana's Trauma System. For the rest of 2011, members agreed to follow Trauma Registry data for temperature documentation and documentation of warming measures implemented for some degree of hypothermia (< 96 degrees) to determine our degree of issue.

Jennie will further explore Clinical Guidelines components and introduce the topic/provide the information during the MT Trauma Systems Conference in September, all of the RTACs and disseminate the information over the Trauma Listserve. STCC will consider disseminating this strategy as a PI focus and EMS & Trauma will trend the TR data on temperature information for 2011.

**B. The Board Of Medical Examiners** has offered an individual the position of EMS Medical Director. STCC members would like to invite the new EMS Medical Director to the next STCC meeting to hear his/her plans for the position and to forge additional linkages with the State Trauma Care Committee. Members expressed the hope that he/she will routinely attend STCC meetings providing additional perspective, expertise and act as a resource as we continue to develop and link our systems of care in Montana. Jennie will contact BOME and invite him/her to the next meeting if the position has been filled and that person is here/available to attend.

**VII. Telemedicine Consults in ERTAC- Dennis Maier**

St. Vincent Healthcare has partnered with Denver Children's Hospital to provide Telemedicine-based Pediatric neurosurgical consultation. The availability of Pediatric Neurosugerical care for injured patients has been a national issue and certainly is in Montana, primarily in the Eastern and Western Regions. Many facilities have had issues attempting to find neurosurgeons willing to accept Pediatric neurotrauma patients and have worked to establish local plans for transferring appropriate sick pediatric neurotrauma patients . Dr Maier described recent pediatric neurotrauma cases that have been very positive, with Denver providing frequent telemedical oversight of specific patient management, family conferences and the availability of full medical consultation with dictation. SVH is developing their teleconsultation systems with Eastern Region facilities & Dr Maier encouraged the other larger MT regional facilities to consider

implementation of Telemedicine systems to improve medical specialty/subspeciality access and meet on-going and emerging trauma patient needs.

**Public Comment**

None received.

**Adjournment**

**Dennis Maier** adjourned the meeting.
**The next State Trauma Care Committee meeting will be held in Helena, WEDNESDAY, November 9, 2011.**

Case Reviews included;

ERTAC: Scene Triage/Decision-making when local resources have been exhausted; multiple MVC during winter with all other ambulances responding to other calls/few responding resources available. Multiple patients, 2-3 critical, and few on-scene providers, one paramedic. Challenges/issues illustrated; communications, on-scene ICS, decisions whether to provide care on-scene, transport which patients/service, responsibility for decisions, contacting hospital Medical Control to assist in decision-making, when to implement/revise/suspend "usual" EMS procedures of;"first on-scene, last off-scene", and associated capability considerations.

STCC advised on-going local case review involving all responders/participants & the facility in order to review procedures, clarify plan components, evaluate processes and provide for future local planning and define "contingencies" for unusual circumstances.

WRTAC: Male patient with existing pathology sustaining neck trauma initially cared for in first facility and transferred to regional facility for higher level of care. Challenges/issues illustrated; identification of injury severity, appropriateness of available transfer modality/transfer capabilities, communications and assessment/interventions.

STCC members discussed requirements for Emergency Department coverage for medical providers, the importance of standardized approaches for clinical trauma care and recommends "minimum Advanced Trauma Life Support or comparable board certification for all medical providers covering Emergency Departments in Montana."

CRTAC; Male patient sustaining severe trauma @ industrial scene, EMS resuscitation with advanced management interventions implemented in the field during transport. Challenges/issues illustrated; Patient 'hand-off " reporting EMS to Trauma Team may result in information not clearly heard by Trauma Team members due to room and team noise with the potential to miss communication of history, pertinent pre-hospital interventions and subsequent variation in patient management. The facility has re-implemented the "moment of silence" approach to initial EMS report for trauma patients until EMS report is heard by all Team members in the room for clarity and continuity of care.

STCC advised dissemination of the "moment of silence" approach to the RTACS and Trauma Program staff to ensure effective communications.

Minutes respectfully submitted by Jennie Nemec, RN, Trauma System Manager

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